




JUL 14 2003

**TO:** Neil Donovan  
Director, Audit Liaison Staff  
Centers for Medicare and Medicaid Services

**FROM:** Dennis J. Duquette   
Deputy Inspector General  
for Audit Services

**SUBJECT:** Medicaid Payments for School-Based Health Services - Massachusetts Division of Medical Assistance - July 1999 Through June 2000 (A-01-02-00009)

As part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance within 5 business days of our final audit report entitled, "Medicaid Payments for School-Based Health Services - Massachusetts Division of Medical Assistance - July 1999 Through June 2000." A copy of the report is attached. This report is one in a series of reports in our multi-state initiative focusing on costs claimed for Medicaid school-based health services. We suggest you share this report with the Centers for Medicare and Medicaid Services (CMS) components involved in program integrity, provider issues, and state Medicaid agency oversight, particularly the Center for Medicaid and State Operations.

The objective of our audit was to determine whether costs claimed for school-based health services by the Massachusetts Division of Medical Assistance (DMA) were reasonable, allowable, and adequately supported in accordance with the terms of the state Medicaid plan and applicable federal regulations. We also reviewed DMA's oversight of the school-based program.

Based on our review of claims data at the eight selected local education agencies (LEA), we estimated that at least \$2,997,268 (federal share) was ineligible for reimbursement. In this regard, we found that:

- sufficient documentation was not always maintained to ensure that services prescribed in the students' individualized education plans (IEP) were delivered;
- school-based health services were rendered by health care providers that did not have the qualifications required by DMA Medicaid regulations; claims were submitted for students who were absent;
- IEPs were not available to cover periods in which the Medicaid program was billed; and the school-based service type was sometimes billed incorrectly.

Overall, we found DMA's oversight and monitoring of school-based services to be less than adequate. In addition, contrary to CMS instructions, the DMA continued to use a bundled rate methodology to claim Medicaid reimbursement. We also noted that the University of Massachusetts (UMass) transmitted Medicaid data via the Internet without proper security

measures and provided listings of all Medicaid beneficiaries or eligibles to the LEAs even though CMS precludes such actions to ensure privacy.

We recommended that the DMA: (1) provide training and technical assistance to LEAs, (2) review all guidance UMass issued to LEAs relative to the Massachusetts Medicaid school-based health program for clarity and completeness and reissue, as needed, (3) design a monitoring/audit system to ensure that LEAs comply with Medicaid requirements, (4) develop a new fee-for-service methodology for school-based health services that complies with federal documentation requirements, (5) discontinue providing listings of Medicaid eligible students to LEAs, (6) establish procedures consistent with CMS requirements regarding electronic transmission of data which contain uniquely identifying information, and (7) refund to CMS the \$2,997,268 (federal share) that was inappropriately paid by the Medicaid program to the eight LEAs.

The DMA apprised us it has taken, or plans to take, action on all of the procedural recommendations above. Further, the DMA agrees with three of the five conditions noted above regarding our review of claims data at the eight selected LEAs. However, the DMA disagrees with our recommendation to refund the entire \$2,997,268 (federal share) to CMS. The DMA did not quantify its disagreement but did state it disagrees with any portion of the recommended refund that relates to service documentation and provider qualifications.

Notwithstanding DMA's disagreement with the monetary finding contained in our report, we are pleased that DMA is taking, or agreed to take, action on our procedural recommendations without the need for additional regulatory guidance. For reasons articulated in detail in our reports to the eight LEAs, we disagree with DMA's position regarding the financial adjustment. Further, when the LEAs provided us with additional documentation and information subsequent to the issuance of the draft reports, we did make changes, where appropriate, to our final reports. The DMA's comments are summarized in the body of our report and included in their entirety as APPENDIX E. We address all of DMA's concerns in the body of this report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689. To facilitate identification, please refer to report number A-01-02-00009 in all correspondence.

Attachment



Office of Audit Services  
Region I  
John F. Kennedy Federal Building  
Boston, MA 02203  
(617) 565-2684

JUL 16 2003

Report Number: A-01-02-00009

Mr. Douglas S. Brown  
Acting Commissioner  
Division of Medical Assistance  
Executive Office of Health and Human Services  
Commonwealth of Massachusetts  
600 Washington Street  
Boston, Massachusetts 02111

Dear Mr. Brown:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Medicaid Payments for School-Based Health Services - Massachusetts Division of Medical Assistance - July 1999 Through June 2000." A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.)

To facilitate identification, please refer to report number A-01-02-00009 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink, reading "Michael J. Armstrong". The signature is fluid and cursive, with the first name "Michael" and last name "Armstrong" clearly legible.

Michael J. Armstrong  
Regional Inspector General  
for Audit Services

Enclosures - as stated

Page 2 – Mr. Douglas S. Brown

**Direct Reply to HHS Action Official:**

Charlotte Yeh, M.D.

Regional Administrator

Centers for Medicare and Medicaid Services

Department of Health and Human Services

John F. Kennedy Federal Building, Room **2325**

Boston, Massachusetts **02203-0003**

cc:

Frank McNamara, Director, Internal Control and Audit, Division of Medical Assistance,  
Executive Office of Health and Human Services, Commonwealth of Massachusetts

John Robertson, Associate Vice Chancellor, Center Director, Center for Health Care  
Financing, University of Massachusetts Medical School

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICAID PAYMENTS FOR  
SCHOOL-BASED HEALTH SERVICES –  
MASSACHUSETTS DIVISION OF  
MEDICAL ASSISTANCE – JULY 1999  
THROUGH JUNE 2000**



**JULY 2003  
A-01-02-00009**

# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHSIOIGIOAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

## **EXECUTIVE SUMMARY**

### **Background**

The Medicaid program was established by title XIX of the Social Security Act and is jointly funded by the Federal and State governments to provide medical assistance to pregnant women, children, and needy individuals who are aged, blind, or disabled. In Massachusetts, the Division of Medical Assistance (DMA) is the state agency responsible for administering the Medicaid program. The DMA contracts with the University of Massachusetts Medical School, Center for Health Care Financing, Municipal Medicaid (UMass) to administer the school-based health services portion of the Medicaid program. School-based health services reimbursable under the Medicaid program are provided by or through the Massachusetts Department of Education (DOE) or a local education agency (LEA) to students with special needs pursuant to an individualized education plan (IEP). Services are provided in the school setting or another site in the community and include speech therapy, physical therapy, occupational therapy, audiological services, behavior management, and/or counseling.

The LEAs were reimbursed \$42,067,293 (Federal share) under the Commonwealth of Massachusetts' Medicaid program during the period July 1, 1999 through June 30, 2000.

### **Objective**

The objective of our audit was to determine whether costs claimed for school-based health services by the DMA were reasonable, allowable, and adequately supported in accordance with the terms of the state Medicaid plan and applicable Federal regulations. To accomplish our objective, we selected claims data submitted from eight LEAs that were reimbursed \$19,828,368 (Federal share) during the period July 1, 1999 through June 30, 2000. We also reviewed DMA's oversight of the school-based program.

### **Summary of Findings**

Based on our review of claims data at the eight selected LEAs, we estimated that at least \$2,997,268 (Federal share) was ineligible for reimbursement. In this regard, we found that:

- sufficient documentation was not always maintained to ensure that services prescribed in the students' IEPs were delivered;
- school-based health services were rendered by health care providers that did not have the qualifications required by DMA Medicaid regulations;
- claims were submitted for students who were absent;
- IEPs were not available to cover periods in which the Medicaid program was billed; and
- the school-based service type was sometimes billed incorrectly.

Overall, we found DMA's oversight and monitoring of school-based services to be less than adequate. Specifically, Medicaid program guidance to the LEAs was not always disseminated and/or adequately explained. Further, DMA/UMass did not monitor or review the LEAs' degree of compliance with federal and state regulations/guidelines applicable to the LEAs' participation in the Medicaid school-based program. Contrary to Centers for Medicare and Medicaid Services (CMS) instructions, the DMA continued to use a bundled rate methodology to claim Medicaid reimbursement. As such, the DMA and LEAs cited the use of a bundled rate as the reason why medical service documentation was not maintained.

We also noted that UMass transmitted Medicaid data via the Internet without proper security measures and provided listings of all Medicaid beneficiaries or eligibles to the LEAs even though CMS precludes such actions to ensure privacy.

## **Recommendations**

We recommended that the DMA: (1) provide training and technical assistance to LEAs, (2) review all guidance UMass issued to LEAs relative to the Massachusetts' Medicaid school-based health program for clarity and completeness and reissue, as needed, (3) design a monitoring/audit system to ensure that LEAs comply with Medicaid requirements, (4) develop a new fee-for-service methodology for school-based health services that complies with Federal documentation requirements, (5) discontinue providing listings of Medicaid eligible students to LEAs, (6) establish procedures consistent with CMS requirements regarding electronic transmission of data which contain uniquely identifying information, and (7) refund to CMS the \$2,997,268 (Federal share) that was inappropriately paid by the Medicaid program to the eight LEAs.

## **Auditee's Comments**

The DMA apprised us it has taken, or plans to take, action on all of the procedural recommendations above. Further, the DMA agrees with three of the five conditions noted above regarding our review of claims data at the eight selected LEAs. However, the DMA disagrees with our recommendation to refund the entire \$2,997,268 (Federal share) to CMS. The DMA did not quantify its disagreement but did state it disagrees with any portion of the recommended refund that relates to service documentation and provider qualifications. The DMA's comments are summarized in the body of our report and included in its entirety as APPENDIX E.

## **Office of Inspector General's Response**

Notwithstanding DMA's disagreement with the monetary finding contained in our report, we are pleased that DMA is taking, or agreed to take, action on our procedural recommendations without the need for additional regulatory guidance. For reasons articulated in detail in our reports to the eight LEAs, we disagree with DMA's position regarding the financial adjustment. Further, when the LEAs provided us with additional documentation and information subsequent to the issuance of the draft reports, we did make changes, where appropriate, to our final reports.



The monetary adjustment to refund to CMS the \$2,997,268 (Federal share) that was inappropriately paid by the Medicaid program to the eight LEAs reflects our consideration of all additional information provided by each LEA. We address all of DMA's concerns in the body of this report.

### **OTHER MATTERS**

In the OTHER MATTERS section of the report, we address the requirement of the LEA to obtain written authorization from the parent or guardian to share educational information with DMA as set forth under Chapter 766 (the Massachusetts special education law) and DMA instructions (*Operational Guide for School Districts*, revised May 1995).

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## INTRODUCTION

### Background

The Medicaid program was established by title XIX of the Social Security Act and is jointly funded by the Federal and state governments to provide medical assistance to pregnant women, children, and needy individuals who are aged, blind, or disabled. Within broad Federal guidelines, states design and administer the program under the general oversight of the Centers for Medicare and Medicaid Services (CMS). In Massachusetts, the Division of Medical Assistance (DMA) is the state agency responsible for administering the Medicaid program. The DMA contracts with the University of Massachusetts Medical School, Center for Health Care Financing, Municipal Medicaid (UMass) to administer the school-based health services portion of the Medicaid program.

School-based health services reimbursable under the Medicaid program are provided by or through the Massachusetts Department of Education (DOE) or a local education agency (LEA) to students with special needs pursuant to an individualized education plan (IEP). Services are provided in the school setting or another site in the community and include speech therapy, physical therapy, occupational therapy, audiological services, behavior management, and/or counseling. The IEP describes the special education and related services, including school-based health services, which the student requires. An IEP must be in compliance with the Individuals with Disabilities Education Act, P.L. 94-142, as amended, and in compliance with requirements of regulations implementing Chapter 766 of the Acts of 1972, M.G.L., Chapter 71B, as amended. Further, LEAs must comply with the DOE and DMA requirements concerning the authorization to share information with the DMA.

To seek Medicaid reimbursement of school-based health services, LEAs must:

- have a provider agreement with the DMA;
- determine whether the student is enrolled in the Medicaid program;
- provide services pursuant to a valid IEP that are in compliance with all Chapter 766 requirements (the Massachusetts special education law);
- assemble and complete documentation that the Medicaid covered service in the IEP has been delivered by a qualified provider before the Medicaid claim is submitted to UNISYS (the DMA Medicaid claims agent) for Federal reimbursement; and
- submit a claim for reimbursement that details the student, dates of attendance, CMS procedure codes (level-of-service), and rates. (The LEAs submit claiming documents to UNISYS in order to obtain Federal reimbursement.)

Massachusetts reimburses LEAs for school-based health services based on the number of days in attendance multiplied by a statewide per diem rate for the program prototype per the student's IEP. According to the Massachusetts' state Medicaid plan, the per diem rate is based on the

Medicaid fee-for-service rate for each service and a statistically representative utilization rate for those services.

The Commonwealth of Massachusetts had approximately 974,000 students who attended the schools during our audit period in 372 LEAs. Of the 372 LEAs, 272 LEAs submitted claims for 40,289 students receiving special education. On behalf of these students, the 272 LEAs were reimbursed \$42,067,293 (Federal share) under the Commonwealth of Massachusetts' Medicaid program during the period July 1, 1999 through June 30, 2000. We reviewed 8 LEAs (Boston Public Schools, Fall River Public Schools, Haverhill Public Schools, Holyoke Public Schools, Lynn Public Schools, New Bedford Public Schools, Springfield Public Schools, and Worcester Public Schools), which had approximately 172,000 students who attended the schools during our audit period. These 8 LEAs submitted claims for 18,224 students, for which the 8 LEAs were reimbursed \$19,828,368 (Federal share), under the Commonwealth of Massachusetts' Medicaid program during the period July 1, 1999 through June 30, 2000.

### **Objective, Scope, and Methodology**

The objective of our audit was to determine whether costs claimed for school-based health services by the DMA were reasonable, allowable, and adequately supported in accordance with the terms of the state Medicaid plan and applicable Federal regulations. We selected claims data submitted from eight LEAs that were reimbursed \$19,828,368 (Federal share) during the period July 1, 1999 through June 30, 2000. We also reviewed DMA's oversight of the school-based program.

We did not review the per diem rate used by DMA and the LEAs as UMass officials apprised us that the documentation supporting the per diem rates for the various program prototypes was not retained. (Under contract with DMA, UMass developed the reimbursement methodology in 1993.)

To accomplish our audit objective, we:

- Reviewed Federal and state laws, regulations, and guidelines pertaining to the Medicaid program and special education related to school-based health services. We also reviewed the Commonwealth of Massachusetts' state plan amendment 92-14 that describes the Department of Public Welfare's (now DMA) procedure for reimbursing school-based special needs services.
- Reviewed the Interdepartmental Service Agreement between DMA and UMass that sets forth UMass' responsibilities to provide administrative, management, and technical support to DMA in administering the state Medicaid plan.
- Reviewed eight Massachusetts LEAs to determine whether costs claimed for school-based health services by each of the LEAs through the Commonwealth of Massachusetts were reasonable, allowable, and adequately supported in accordance with the terms of the state Medicaid plan and applicable Federal regulations. The audit period at each LEA included Medicaid payments made during the period July 1, 1999 through June 30, 2000.

- Issued individual reports at the following LEAs:

<b>Local Education Agency</b>	<b>Report Number</b>
Boston Public Schools	A-01-02-00001
Fall River Public Schools	A-01-02-00005
Haverhill Public Schools	A-01-02-00007
Holyoke Public Schools	A-01-02-00004
Lynn Public Schools	A-01-02-00002
New Bedford Public Schools	A-01-01-00005
Springfield Public Schools	A-01-02-00003
Worcester Public Schools	A-01-01-00008

- At the eight LEAs listed above, identified all individual claims made for days when the schools were not in session, including holidays (e.g., Thanksgiving, Christmas, and Memorial Day), winter and spring vacations, professional in-service days, and snow and emergency days. We did not review claims for residential or preschool placement.
- From the 8 LEAs listed above, we selected from a population of 140,656 recipient/months with claims totaling \$19,828,368 (Federal share), a simple random sample of 100 recipient/months from each school district (total 800 recipient/months) representing claims totaling a Federal share of \$103,448 in Medicaid claims paid during our audit period for school-based health services.
- Held discussions with officials from CMS, DMA, UMass, each of the eight LEAs, and several out-of-district schools.

Our audit was conducted in accordance with generally accepted government auditing standards. We performed our field work at the eight Massachusetts LEAs, DMA, and UMass during the period May 2001 through November 2002. See APPENDIX E for the DMA comments in its entirety.

## **FINDINGS AND RECOMMENDATIONS**

Based on our review of claims data at the eight selected LEAs, we estimated that at least \$2,997,268 (Federal share) was ineligible for reimbursement.

We found DMA's oversight and monitoring of school-based services to be less than adequate. Specifically, Medicaid program guidance to the LEAs was not always disseminated, and/or adequately explained. Further, DMA/UMass did not monitor or review the LEAs degree of compliance with Federal and state regulations/guidelines applicable to the LEAs participation in the Medicaid school-based program. Contrary to CMS instructions, the DMA continued to use a bundled rate methodology to claim Medicaid reimbursement. As such, the DMA and LEAs cited the use of a bundled rate as justification why medical service documentation was not maintained.

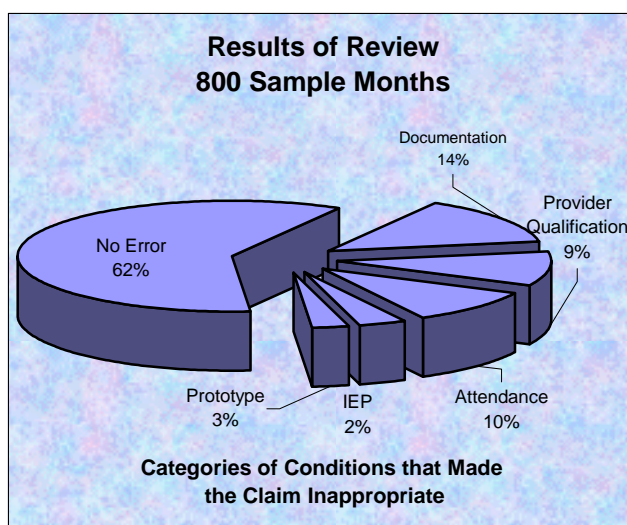
We also noted that UMass transmitted Medicaid data via the Internet without proper security measures and provided listings of all Medicaid beneficiaries or eligibles to the LEAs even though CMS precludes such actions to ensure privacy.

We recommended in the individual reports to the LEAs that the LEAs refund their respective overpayments to the DMA. (See APPENDICES A and B.) We also made procedural recommendations to the LEAs to address the issues.

## RESULTS OF REVIEW AT EIGHT LOCAL EDUCATION AGENCIES

In our review of 800 randomly selected months at 8 LEAs, we found that the LEAs submitted claims for 255 months<sup>1</sup> totaling \$23,698 for school-based health services when there was at least 1 of 5 conditions which made the claim inappropriate:

- LEAs did not maintain sufficient documentation that services prescribed in the IEP were delivered (111 sample months at 8 LEAs);
- School-based health services were rendered by providers that did not have the qualifications required by DMA Medicaid regulations (69 sample months at 5 LEAs);
- The student was absent (78 sample months at 8 LEAs);
- Students did not have a valid IEP for Medicaid billing purposes (18 sample months at 6 LEAs); and
- The wrong prototype was billed (16 sample months at 5 LEAs).



As a result, we estimated that the LEAs were overpaid at least \$2,704,362 (Federal share) and recommended in the individual reports to the LEAs that the LEAs refund their respective overpayments to the DMA. (See APPENDIX A.) We also made procedural recommendations to the LEAs to address the issues.

In addition, in our review of 100 percent of claims for days when the eight LEAs were not in session, we found that five LEAs overbilled the Medicaid program for \$292,906 (Federal share) in reimbursements. We recommended in the individual reports to the LEAs that the LEAs refund their respective overpayments to the DMA. (See APPENDIX B.) This represents the daily per diem rate for school-based health services when the schools were not open to students. We also made procedural recommendations to the LEAs to address the issues.

<sup>1</sup> While some sample units had more than one condition, we did not question more than 100 percent of the claim. (See APPENDIX C.)

We believe that the overriding causes of these issues stem (1) from neither DMA/UMass providing sufficient guidance nor conducting adequate monitoring of the LEA's implementation of the Massachusetts' Medicaid school-based health services program and (2) using a bundled rate methodology developed a decade ago based on the number of days in attendance multiplied by a statewide per diem rate for the program prototype per the student's IEP, for reimbursing LEAs regardless of whether the IEP contains any school-based health services or just educational services.

## Recommendation

We recommended that the DMA:

- Refund to CMS the \$2,997,268 (Federal share) that was inappropriately paid by the Medicaid program to the eight LEAs.

## Auditee's Comments

While the DMA disagrees with our recommendation to refund the entire \$2,997,268 (Federal share) to CMS, they do not dispute our findings regarding student absences, incorrect student prototypes, or valid IEPs for Medicaid billing and agrees that Federal financial participation (FFP) would not be available. However, the DMA did not quantify its disagreement but did state it disagrees with any portion of the recommended refund that relates to **service documentation** and **provider qualifications**. The DMA believes that the CMS approved bundled rate methodology negates most of our financial findings related to **service documentation** and **provider qualifications** as discussed below.

The DMA stated that if any disallowance is deemed appropriate that the approach in establishing the monetary recommendation is flawed. They believed that we did not take into account that the bundled rates are composite rates based on utilization of an array of services and are not tied to a particular service. They believed that, instead of following the approach of disallowing the entire amount of the per diem rate claimed, we should have determined the portion of the rate that applied to the particular service being questioned and only consider that amount to be in error. The DMA believed that our approach resulted in a substantial overstatement of the amount of the inappropriate payment. The DMA asked, that to the extent that we determined that a disallowance was appropriate, the monetary value of such a determination be reassessed.

- **Service Documentation** The DMA stated the Office of Inspector General (OIG) found that the LEAs did not always maintain the types of medical documentation that (a) established the reasonableness or accuracy of the bundled rate and (b) served as evidence that services were provided as required under the Medicaid program. The DMA stated that they provided us with satisfactory documentation for 86 percent of the cases reviewed and that in most of the remaining cases progress and case notes were provided, but rejected by us as inadequate. However, the DMA believed that documentation supplied provided service specific support. The DMA further stated that our adverse findings regarding documentation were based on a rejection of the CMS approved bundled rate methodology. They stated that the rate structure did not consider the need to maintain service specific documentation to support a claim or the rate of payment.

- **Provider Qualifications** The DMA agreed with our finding regarding provider qualifications; however, they stated that the LEAs were not required to utilize Medicaid qualified providers for educational services. The DMA stated that we did not describe the process used to determine whether the services were educational or medical in nature and expressed concern that we do not have the medical, educational, or legal expertise to make such conclusions.

## OIG's Response

For reasons articulated in some detail in the OIG reports to the eight LEAs, we disagree with DMA's position regarding the financial adjustment. Further, when the LEAs provided us with additional documentation and information subsequent to issuance of the draft reports, we did make changes, where appropriate, to our final reports. The monetary adjustment to refund to CMS the \$2,997,268 (Federal share) that was inappropriately paid by the Medicaid program to the eight LEAs reflects the OIG consideration of all additional information provided by each LEA. We do not believe our approach to determine the amount of disallowance was inappropriate; rather it was more conservative.

We did not audit the bundled rate; as such, we did not review documentation to establish the reasonableness or accuracy of the bundled rate. However, regarding documentation and provider qualification findings, we reviewed documentation and provider qualifications when the student's IEP included one or more of the Medicaid reimbursable services listed on the bundled rate worksheets. Thus, we only disallowed a particular sample month when we could not find evidence of any service documentation or qualified providers during the month. Conversely, if the IEP listed more than one health related service, and we found adequate documentation and a qualified provider for only one service, we did not question costs for that sample month.

If OIG were to reassess any sample items it would be the items with more than one Medicaid reimbursable service listed on the IEP that we considered to be allowable. We would need to reassess these items to determine if all Medicaid reimbursable services were documented and delivered by a qualified provider. If we determined through further review that not all Medicaid reimbursable services were documented or delivered by a qualified provider, then we could possibly isolate the value of the specific service and subtract that value from the overall rate. This would likely result in greater total overpayments. Below, we address DMA's concerns related to **service documentation** and **provider qualifications**.

- **Service Documentation** We do not agree that the bundled rate structure precluded states from the requirement to maintain service documentation to support a claim. Based on the current Massachusetts claiming methodology, we agree that not every IEP must have a health related service prescribed in the student's IEP. However, for the IEPs that contained a health related service there should be documentation of the health related services provided. We found that 46 percent (368 IEPs) of the 800 IEPs reviewed contained at least 1 health related service. We were not provided with documentation for 30 percent or 111 of the 368 IEPs.

For the IEPs that prescribed one or more health related service(s), we found the claim to be appropriate if at least one of the health related services was supported by service



documentation. We accepted any documentation that indicated that services were delivered to recipients during our sample month including quarterly progress reports and case notes that covered our sample month. However, we did not accept documentation dated prior to our sample month since there was no assurance that services continued into the sample month. Furthermore, we did not accept IEPs, assessments, or evaluations as documentation that services were provided since they identify only those services that a child should receive and not the services that the child actually received. If we considered a sample month to be in error it was because there was no service documentation provided for any prescribed health related service.

- **Provider Qualifications** The bundled rate worksheets list the following services as health related: behavior management (502.6 only), sensory training, counseling, medical diagnosis/treatment, occupational therapy, physical therapy/adapted physical education, and speech and language/audiological. If one or more of these services were listed on the IEP, we considered the sample item to include a Medicaid reimbursable health related service and to be allowable if we found evidence that at least one of the providers of the Medicaid reimbursable service(s) was qualified. Based on the methodology we employed, it was not within the scope of our audit to review qualifications for providers of educational services.

## STATE OVERSIGHT AND MONITORING

### Program Guidance

Rather than issue guidance directly to LEAs regarding program requirements, DMA delegated its responsibility to UMass to issue program policy to LEAs. However, DMA did not review the program guidance provided by UMass to the LEAs, making the LEAs vulnerable to instructions that were either contradictory or silent on various Medicaid requirements related to documentation and provider qualifications. Likewise, DMA and/or UMass did not monitor or review the LEAs degree of compliance with Federal and state regulations/guidelines applicable to the LEAs participation in the school-based health services program.

For example, several LEAs apprised us that the reason they did not comply with Medicaid requirements relative to documentation of services delivered and Medicaid licensure requirements was because the guidance provided by UMass was not clear in that it differed with guidance provided by DOE in 1992 or was silent.

- Relative to documentation of services delivered, one LEA cited a DOE 1992 *Fact Sheet – Massachusetts Municipal Medicaid Program for Special Education Services* which stated, “The unique feature of the Massachusetts system is that it does not require schools to keep records of each health related service they provide to each child enrolled in Medicaid and on an IEP....”
- Other LEAs stated they believed they were not required to keep records of each health related service they provided to each student and that the student’s attendance record and IEP were sufficient for billing and documentation purposes.

The DMA - not the DOE - is the state agency responsible for issuing policies, particularly related to reimbursement for the Massachusetts' Medicaid school-based program. Further, the 1992 DOE statement differs from later DOE, UMass, and CMS guidance as well as with the provider agreements each LEA signed in 1993 or 1994 with DMA to participate in reimbursement under the school-based health program.

The LEAs should have been following the Commonwealth of Massachusetts' *Operational Guide for School Districts* (issued by DOE in September 1993 and revised by UMass in May 1995), which required that in addition to attendance records, schools assemble and complete documentation that any Medicaid covered service in the IEP has been delivered [emphasis added] before the Medicaid claim is submitted to UNISYS for Federal reimbursement. Further, the CMS's *Medicaid and School Health: A Technical Assistance Guide*, dated August 1997, page 40, states:

A school, as a provider, must keep organized and confidential records that details client specific information regarding all specific services provided for each individual recipient of services and retain those records for review...Relevant documentation includes the dates of service....

Moreover, the provider agreement the LEAs signed required the LEAs "To comply with all state and Federal statutes, rules, and regulations applicable to participation in the Medical Assistance Program...To keep such records as are necessary to disclose fully the extent of the services to recipients...To furnish...Federal officials...such information, including copies of medical records, regarding any services for which payment was claimed...."

Relative to Medicaid licensure requirements, the state Medicaid plan, Supplement 2 to Attachment 4.19-B (dated June 20, 1992), stated that direct care providers employed or contracted by the school districts must comply with all qualifications for that provider type, including any state licensure and certification requirements. While all of the provider agreements between DMA and the LEAs stated that LEAs were to comply with all Federal and state statutes, rules, and regulations applicable to the LEAs' participation in the school-based health program, six of the eight provider agreements also stated that direct care providers employed or contracted by the provider must comply with the qualifications for that provider type established under the applicable DMA regulations. However, we did not note any guidance to LEAs, which specifically cited the DMA licensure requirements for Medicaid payments for speech therapy, physical therapy, occupational therapy, and counseling as set forth in the DMA, Provider Manual Series, *Therapist Manual*, *Psychologist Manual*, and *All Provider Manual*.

While there is room for improvement in the guidance DMA/UMass provided the LEAs, we believe that the Medicaid documentation requirements set forth in DOE/UMass guidance from 1993 forward, especially when coupled with CMS guidance and the provider agreements that the LEAs signed are sufficiently clear and that the Medicaid licensure requirements are clearly set forth in Massachusetts' Medicaid regulations.

In addition, the LEAs were required to provide all the state's share of matching funds under the Medicaid program. Because the state's resources were not used to fund the program, there was

little incentive provided to DMA to monitor the program. In this regard, the DMA/UMass did not implement a monitoring/audit program of the LEAs to determine the LEAs' degree of compliance with Federal and state regulations/guidelines applicable to the LEAs' participation in the Medicaid school-based health program. We believe that proper and timely reviews of claims and supporting documentation by DMA would reduce the risk that LEAs would submit claims for reimbursement that were inappropriate. Such reviews would facilitate identifying areas where the LEAs need additional training/technical assistance and areas where DMA should issue clarifying guidance.

### **Bundled Rates**

We noted that LEAs, reimbursed under the bundled rate methodology, do not maintain the types of medical documentation that established the reasonableness or accuracy of the rate and that served as evidence that services were provided as required under the Medicaid program. In fact, DMA and LEA officials often cited the state's use of the bundled rate methodology as reasons why documentation was not needed to provide evidence that medical services were provided.

A May 1999 directive from CMS instructed state Medicaid agencies that employ a bundled rate for reimbursing LEAs for school-based health services to change from a bundled rate methodology to an alternative reimbursement methodology. The directive though, stated that CMS would like to work with the states to implement a strategy so that states came into compliance prospectively. In this regard, the CMS directive stated that "effective immediately" CMS would no longer recognize bundled school-based health service rates as acceptable for purposes of claiming FFP.

Further, the Interdepartmental Service Agreement (ISA) between the DMA and UMass in Attachment A, IV.B. School-Based Services Rate Project, December 28, 1999 stated:

HCFA [CMS] has instructed all state Medicaid programs that use a bundled rate methodology for school-based services to design and develop a new fee-for-service methodology that complies with Federal service documentation requirements. A new unbundled rate will be developed and billing and service documentation modified to comply with the new Federal mandate.

The bundled rate methodology was developed by DMA/UMass over a decade ago, was never updated and documentation supporting its development no longer exists. The rate currently applies to all IEPs that contain either medical only, educational only, or both types of services. The methodology used to develop the rate spreads the costs of medical services over all IEPs (including those not involving medical services). We believe this violates regulations which state that non-medical services were not to be claimed. In our review of 800 recipient/months and related IEPs (100 each at 8 LEAs), we found that 54 percent of the IEPs did not prescribe any school-based health services. Yet these services were all claimed for FFP.

As of June 2003, 50 months later, DMA has yet to revise its current rate methodology. The UMass officials apprised us that they had not started developing a fee-for-service rate structure as they were waiting for specific instructions from CMS.

We believe that the May 21, 1999 CMS letter is clear that the bundled rate methodology is no longer acceptable for purposes of claiming FFP and that DMA should have developed an alternative reimbursement methodology for review by CMS. Unless DMA/UMass comply with CMS's directive to develop an alternative rate methodology, we believe the risk is high that LEAs will continue to submit claims that are questionable for FFP.

## **Recommendations**

We recommended that the DMA:

- Provide training and technical assistance to LEAs regarding the issues identified in our review of the individual LEAs.
- Review all guidance UMass issued to LEAs relative to the Massachusetts' Medicaid school-based health program for clarity and completeness and reissue, as needed.
- Design a monitoring/audit system to ensure that LEAs comply with Medicaid requirements.
- Design and develop a new fee-for-service methodology for school-based health services that complies with Federal documentation requirements.

## **Auditee's Comments**

The DMA apprised us it has taken, or plans to take, action on all of the above procedural recommendations. However, DMA had additional concerns regarding the bundled rate methodology as discussed below.

**Bundled Rate Methodology** The DMA comments concluded that our position regarding the bundled rate methodology was incorrect. Regarding the CMS (then HCFA) letter dated May 21, 1999 concerning the use of bundled rates for Medicaid reimbursement of school-based health services, DMA acknowledged that the letter stated that new bundled rate methods would not be approved; however, they further stated that the letter did not prohibit claiming of FFP for any state, including the Commonwealth, with a preexisting approved bundled rate. The DMA stated that they have not implemented an alternative reimbursement method since CMS had not issued any guidance regarding bundled rates. The DMA strongly refuted our assertion that bundled rates were currently unacceptable for purpose of claiming FFP.

The DMA disagreed that billing for non-medical services (education only) violated regulations. They stated that they were not aware of any Federal regulation that prohibits the CMS approved bundled rate methodology. They also stated that the bundled rate was developed to account for the fact that certain Medicaid eligible special education students either (a) would not have a medical service component listed in their IEPs or (b) would

not actually receive a Medicaid reimbursable service on a particular day that a bundled rate claim was filed on their behalf. They further stated that CMS participated in the Commonwealth's rate development and approval process and that there was never any specific objection made to a bundled rate methodology that spreads allowable costs over all Medicaid eligible students.

## **OIG's Response**

We are pleased that DMA is taking, or agreed to take, action without the need for additional regulatory guidance. Below, we address DMA's additional concerns regarding the bundled rate methodology.

**Bundled Rate Methodology** While the May 21, 1999 letter stated that CMS would like to work with states to implement a strategy so that states could come into compliance, the letter did not require states to wait for instructions from CMS before developing a new reimbursement methodology. As indicated previously in the report, the DMA began to take action to develop a new reimbursement methodology as evidenced by the ISA between the DMA and UMass; however, the DMA has yet to establish a new reimbursement methodology. We believe that over 4 years, since the issuance of the letter, is an unreasonable amount of time. Also, the May 21, 1999 letter stated that if a new reimbursement methodology was not developed within a reasonable time, CMS would consider taking a compliance action, including deferrals and retrospective disallowances to the date of the letter.

In regard to LEAs claiming reimbursement for students who do not receive any Medicaid reimbursable services, we did not question costs based on the bundled rate methodology used for billing. However, we believe that it is inappropriate that the Medicaid program should reimburse LEAs for students who only receive educational special education services. As stated in the background section of the report, the Medicaid program was established to provide medical assistance. The DMA acknowledges this through the state plan amendment that they entered into with CMS covering school-based health services. Supplement 2 to Attachment 4.19-B page 1 of the state plan amendment stated that municipally based health care services did not include educational services.

## **PRIVACY**

UMass and the eight LEAs followed practices which put the privacy of Medicaid recipients at risk. Contrary to Federal requirements, UMass inappropriately transmitted CMS Privacy Act protected and sensitive information over the Internet and annually provided lists of all children (ages 3 through 21) who were Medicaid beneficiaries or eligibles in the area serviced by each LEA.

## Electronic Privacy

Contrary to the requirements set forth in CMS's *Internet Security Policy*, effective November 24, 1998, UMass did not follow the fundamental rules and systems security requirements for the use of the Internet to transmit CMS Privacy Act-protected and sensitive information. In this regard, CMS's Internet Security Policy provided:

It is permissible to use the Internet for transmission of HCFA Privacy Act-protected and/or other sensitive HCFA [now CMS] information, as long as an acceptable method of encryption is utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information.

Further, in the ISA, dated December 28, 1999 between DMA and UMass, UMass agreed that it will not transmit personal data over the Internet without written permission of DMA.

As discussed in the finding below, entitled *Medicaid Lists*, UMass annually provided a list via hardcopy or floppy disk, including Medicaid numbers, of all children (ages 3 through 21) who were Medicaid beneficiaries or eligibles in the area serviced by each LEA. The list included the child's name, address, age, Medicaid number, date of birth, eligibility dates, category of assistance, and primary care provider or health maintenance organization (HMO) provider. One of the LEAs we reviewed apprised us that when the LEA experienced difficulty with reading data on the floppy disk UMass provided, they would return the disk to UMass and UMass would use the Internet to e-mail the data back to the LEA without any security measures, such as encrypting or password protecting the data. UMass officials stated that the person transmitting the data was not aware of the Internet security requirements.

## Medicaid Lists

For all eight LEAs reviewed, UMass annually provided a list, including Medicaid numbers, of all children (ages 3 through 21) who were Medicaid beneficiaries or eligibles in the area serviced by each LEA. The lists provided were not limited to students receiving special education. UMass officials apprised us they also provided a list of children who are Medicaid beneficiaries or eligibles to all LEAs in the Commonwealth. This is contrary to guidance provided by CMS. The CMS's *Medicaid and School Health: A Technical Assistance Guide*, dated August 1997, page 71, states:

Schools cannot receive a list of children who are Medicaid beneficiaries or eligibles, as the Medicaid Agency may not submit lists of eligibles to other agencies. In order to compile such a list, the school or school system must first submit to the Medicaid Agency a list of children receiving services for Medicaid Agency confirmation. The Medicaid Agency may then run lists from an education agency against its own files with replies to Education only for those children found to be already eligible for Medicaid.

The above guidance is based on 42 CFR 431.306, which provides that state agencies must not publish names of Medicaid applicants or recipients.

School officials apprised us they use these lists to match against their roster of students receiving special education services to determine whether the school system is seeking Medicaid reimbursement and to prepare their administrative costs claim. (The information provided by UMass includes the child's name, address, age, Medicaid number, date of birth, eligibility dates, category of assistance, and primary care provider or HMO provider.) For students so identified, the LEAs will then contact the student's parent for authorization to seek Medicaid reimbursement for providing special education services. By UMass providing LEAs with the Medicaid listing, persons who may not want their status known to school officials are denied their right to privacy.

Relative to using the Medicaid eligible lists to prepare their administrative costs claim, we do not believe LEAs need the detailed personal data on the Medicaid eligible lists to prepare their administrative costs claim. A summary of data would be sufficient.

### **Recommendations**

We recommended that the DMA:

- Discontinue providing listings of Medicaid eligible students to LEAs.
- Develop guidance, consistent with CMS requirements, when transmitting data electronically, which contain uniquely identifying information.

### **Auditee's Comments**

The DMA stated that we uncovered one instance where personal information was inappropriately transmitted over the Internet. While they acknowledged that the transmission of subject identified data over an unencrypted Internet line is unacceptable, they stated that the transmission was inadvertent and not the ordinary practice of the Commonwealth or UMass. They stated that all parties have been reminded of the inappropriate nature of such actions and are certain that it was an isolated incident and will not occur again.

In addition, the DMA did acknowledge that UMass transmitted Division generated lists of Medicaid eligible students to the LEAs; however, they stated that they discontinued this practice more than 2 years ago. They further stated that they had not generated such a list since that time. The DMA stated that they are developing a revised policy to be compliant with the privacy requirements of the Health Insurance Portability and Accountability Act.

### **OIG's Response**

We are pleased that the DMA took action to ensure that personally identifying information will not be inappropriately transmitted in any fashion in the future.

## OTHER MATTERS

Chapter 766 (the Massachusetts special education law) and DMA instructions (*Operational Guide for School Districts*, revised May 1995), require written authorization to share educational information with the DMA. We found that, in 387 of the 800 sample months that we reviewed, 6 of 8 LEAs did not always obtain an "authorization" signed by either a parent or guardian to share information with the DMA for the purpose of submitting claims for Medicaid reimbursement for school-based health services. Further, three of the LEAs, Boston Public Schools, Lynn Public Schools, and Springfield Public Schools, did not require an "authorization" signed by either a parent or guardian to share information with the DMA for the purpose of submitting claims for Medicaid reimbursement for school-based health services. In addition, five of the LEAs where they did obtain authorizations to share information, the request for authorizations were not in the primary language of the student's home, as recorded on the IEP. Accordingly, we have no assurance that the parents of special education students attending the eight LEAs were informed about or gave consent to sharing their child's confidential information with the state Medicaid agency. This requirement does not preclude the state agency from billing Medicaid for school-based health services. (See APPENDIX D.) We did not question Medicaid payments made on behalf of these students.



## **APPENDICES**

**Medicaid Payments for School-Based Health Services  
at Eight Local Education Agencies in Massachusetts  
- July 1, 1999 Through June 30, 2000 -**

**Summary of Statistical Samples at Eight Local Education Agencies**

	<b>Boston A-01-02-00001</b>	<b>Fall River A-01-02-00005</b>	<b>Haverhill A-01-02-00007</b>	<b>Holyoke A-01-02-00004</b>	<b>Lynn A-01-02-00002</b>	<b>New Bedford A-01-01-00005</b>	<b>Springfield A-01-02-00003</b>	<b>Worcester A-01-01-00008</b>	<b>Total</b>
<b>Sample Size</b>	100	100	100	100	100	100	100	100	800
<b>Value of Sample</b>	\$14,500	\$14,105	\$8,129	\$12,772	\$11,566	\$17,585	\$12,021	\$12,770	\$103,448
<b>No. of Errors</b>	25	11	49	29	34	44	44	19	255
<b>Value of Errors</b>	\$3,191	\$923	\$3,684	\$3,268	\$4,082	\$3,328	\$4,309	\$913	\$23,698
<b>Population Size (Recip/Months)</b>	64,463	7,364	2,918	8,482	9,387	13,726	17,991	16,325	140,656
<b>Value of Population</b>	\$9,759,660	\$1,095,125	\$253,287	\$1,065,413	\$1,094,239	\$2,340,129	\$2,187,563	\$2,032,952	\$19,828,368
<b>Point Estimate</b>	\$2,056,698	\$68,001	\$107,507	\$277,191	\$383,172	\$456,768	\$775,232	\$149,059	\$4,273,628
<b>Confidence Level</b>	90%	90%	90%	90%	90%	90%	90%	90%	
<b>Lower Conf. Limit</b>	\$1,237,421	\$25,941	\$81,902	\$191,551	\$250,901	\$290,193	\$558,676	\$67,777	\$2,704,362
<b>Upper Conf. Limit</b>	\$2,875,976	\$110,062	\$133,113	\$362,831	\$515,442	\$623,344	\$991,788	\$230,341	\$5,842,897
<b>Sample Precision +/-</b>	+/- 39.83%	+/- 61.85%	+/- 23.82%	+/- 30.90%	+/- 34.52%	+/- 36.47%	+/- 27.93%	+/- 54.53%	

**Medicaid Payments for School-Based Health Services  
at Eight Local Education Agencies in Massachusetts  
- July 1, 1999 Through June 30, 2000 -**

**Summary of Days Schools Not Open to Students - 100 Percent Review**

	<div><div>Boston A-01-02-00001</div><div>Fall River A-01-02-00005</div><div>Haverhill A-01-02-00007</div><div>Holyoke A-01-02-00004</div><div>Lynn A-01-02-00002</div><div>New Bedford A-01-01-00005</div><div>Springfield A-01-02-00003</div><div>Worcester A-01-01-00008</div><div>Total</div></div>								
Errors OAS Reported	\$3,105	\$1,707	-	-	\$8,510	\$264,226	\$15,358	-	\$292,906

**Medicaid Payments for School-Based Health Services  
at Eight Local Education Agencies in Massachusetts  
- July 1, 1999 Through June 30, 2000 -**

**Summary of Sample Items for School-Based Health Services Inappropriately Claimed**

		Boston A-01-02-00001	Fall River A-01-02-00005	Haverhill A-01-02-00007	Holyoke A-01-02-00004	Lynn A-01-02-00002	New Bedford A-01-01-00005	Springfield A-01-02-00003	Worcester A-01-01-00008	Total
<b>Documentation</b>	Error	17	5	15	7	22	11	30	4	111
	Dollars	\$2,580.20	\$658.49	\$1,135.73	\$765.16	\$3,558.38	\$1,946.83	\$3,713.88	\$527.28	\$14,885.95
<b>Provider Qualification</b>	Error	2		33	18	8		8		69
	Dollars	\$619.12		\$2,542.98	\$2,138.96	\$1,149.45		\$771.17		\$7,221.68
<b>Attendance</b>	Error	4	5	1	2	4	39	12	11	78
	Days	7	16	1	2	4	179	44	21	274
	Dollars	\$52.23	\$108.98	\$5.57	\$17.76	\$28.90	\$2,134.22	\$364.24	\$143.45	\$2,855.35
<b>IEP</b>	Error	1	3		4	3	4		3	18
	Days	15	53	N/A	70		69	N/A	35	242
	Dollars	\$83.55	\$295.21		\$389.90	\$206.09	\$825.65		\$194.95	\$1,995.35
<b>Prototype</b>	Error	2			2	7		2	3	16
	Days	20	N/A	N/A	33	93	N/A	21	19	186
	Dollars	(\$132.40)			\$218.46	\$50.80		(\$139.02)	\$112.54	\$110.38
<b>Total Claims **</b>	Error	25	11	49	29	34	44	44	19	255
	Dollars	\$3,190.51	\$923.43	\$3,684.28	\$3,267.99	\$4,081.94	\$3,327.76	\$4,309.00	\$913.07	\$23,697.98

\*\* While some sample units had more than one condition, we did not question more than 100 percent of the claim. Accordingly, the amounts of Total Claims do not mathematically total, but are the claims which were inappropriately paid. These claims paid in error were used in our projection of total claims inappropriately paid. See APPENDIX A.

**Medicaid Payments for School-Based Health Services  
at Eight Local Education Agencies in Massachusetts  
- July 1, 1999 Through June 30, 2000 -**

**Summary of Authorization to Bill Medicaid**

	Boston A-01-02-00001	Fall River A-01-02-00005	Haverhill A-01-02-00007	Holyoke A-01-02-00004	Lynn A-01-02-00002	New Bedford A-01-01-00005	Springfield A-01-02-00003	Worcester A-01-01-00008	Total
No Authorization / Passive Consent	100	-	48	-	100	38	90	11	387
Not in Primary Language	4	-	6	-	2	6	-	1	19
Passive Consent Forms Mailed Written in English and Spanish Only	X	-	-	-	X	-	X	-	-



**The Commonwealth of Massachusetts**  
**Executive Office of Health and Human Services**  
**Division of Medical Assistance**  
**600 Washington Street**  
**Boston, Massachusetts 02111**

Rpt. No: A-01-02-00009  
APPENDIX E  
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April 25, 2003

Michael J. Armstrong, Regional Inspector General  
Office of the Inspector General  
Office of Audit Services, Region 1  
JFK Federal Building, Room 2425  
Boston, MA 02203

Dear Mr. Armstrong:

This letter represents the Division of Medical Assistance's (Division) response to the draft final report (number A-01-02-00009) of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services (OIG), entitled "Medicaid Payments for School-Based Health Services – Massachusetts Division of Medical Assistance – July 1999 Through June 2000."

The stated objective of the audit on which the report is based was to determine whether costs claimed by the Commonwealth's Municipal Medicaid providers were "reasonable, allowable, and adequately supported in accordance with the terms of the state Medicaid plan and applicable federal regulations." The auditors reviewed claims data submitted by eight local educational authorities (LEAs) for the period from July 1, 1999, through June 30, 2000. The total federal reimbursement for these LEAs over the period was \$19,828,368. Of this amount, the auditors concluded that \$2,997,268 was not eligible for federal reimbursement.

The OIG based its disallowance recommendation on the following findings:

- Instances were found where LEAs claimed a per diem rate on days where the student for whom a claim had been filed was absent from school.
- Five of the eight LEAs reviewed had claimed a per diem rate on days when school was not in session.
- Six of the LEAs had not maintained an up-to-date Individualized Education Program (IEP) document or did not have an IEP on file as required to support a claim for Medicaid payment.
- Five of the LEAs had claimed a per diem rate for the incorrect student prototype. (This error resulted in both over- and underpayments.)

- The LEAs did not have available for OIG review sufficient service-specific documentation to demonstrate that services prescribed in the IEP had been delivered.
- Five of the LEAs reviewed received payment for school-based health services delivered by providers who did not have the professional qualifications required by the Division's regulations.

## **Part I. Introduction**

The Division is confident that its response negates the bulk of the OIG's assertions. Each of the OIG's findings is specifically addressed in the remainder of this response. In addition, the Division requests that the OIG and the Centers for Medicare and Medicaid Services (CMS) consider the Commonwealth's audit in a broader context.

Massachusetts is one of more than a dozen states undergoing an audit of school-based Medicaid services. In Region I alone, four states are being audited. The nationwide audits have uncovered a number of common issues, including questions regarding the adequacy of service-specific documentation and the professional qualifications of some service providers.

The breadth of the OIG's nationwide findings suggests states have not received clear guidance from the federal government regarding school-based services. General Accounting Office (GAO) reports from 1999 and 2000, in fact, cite HCFA guidance regarding school-based Medicaid claiming as insufficient. A 1999 State Medicaid Directors' letter about payment methodologies for school-based services promised forthcoming guidance from HCFA. To date, no further directives have been issued. In 2002, the Commonwealth actively participated in a seven-state workgroup with representatives from CMS to address the confusion and inconsistencies around school-based Medicaid. The group has since become inactive, and the Division, along with the other workgroup states, is still awaiting specific federal guidance.

In these extremely difficult budget times, it is inappropriate to hold a few individual LEAs or states financially liable for what amounts to a national problem. Instead, the Division strongly urges the OIG to recognize the universality of its findings, and to propose prospective programmatic changes, supported by enhanced CMS guidance, instead of retrospective disallowances. The Division also urges CMS, informed by the OIG's findings, to issue prospective policy clarifications applicable to every state. Such an approach is fair, evenhanded, and will require *all* states to systematically address national issues related to school-based Medicaid claiming.

Despite a lack of guidance from CMS, the Division is committed to maintaining a school-based Medicaid program that addresses the concerns raised by the OIG in this audit, and is taking a number of proactive steps to address the audit findings. These actions are fully outlined in Part III of this response.

## **Part II. The Division's Response to Specific OIG Findings**

### **1. OIG's Findings Regarding the Division's Bundled Rate Methodology**

In the audit, the OIG states that:

- (1) A May 1999 State Medicaid Directors' Letter instructed states to change from a bundled rate methodology to an alternative reimbursement methodology and asserted that bundled rates would no longer be acceptable for purposes of claiming FFP; and
- (2) The bundled rate methodology, which spreads the costs of medical services over all IEPs (including those not involving medical services), "violates regulations that state that non-medical services were not to be claimed."

The OIG position regarding bundled rates, as stated above, is incorrect. The Division agrees that on May 21, 1999, CMS [then HCFA] issued a State Medicaid Directors' Letter regarding bundled rates (the "1999 Letter"). The 1999 Letter advised all state Medicaid directors that new bundled rate methods would no longer be approved, and that all states with unapproved, pending state plan amendments (SPAs) had to withdraw them. The 1999 Letter did not, however, prohibit claiming of FFP for any state, including the Commonwealth, with a preexisting approved bundled rate SPA. The Commonwealth's bundled rate SPA was approved by CMS in 1994. Moreover, the 1999 Letter specifically indicated that "[a]t this time, no retroactive disallowances of FFP are planned nor are prospective deferrals" for states claiming under a bundled rate.

The audit accurately notes that CMS stated in the 1999 Letter that it would work with states to develop alternative rate methodologies. In fact, however, CMS has never issued further guidance to the Commonwealth, nor to any other state, regarding bundled rates. Indeed, in its April 2000 report, *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight*, the GAO took issue with CMS' actions following the issuance of its 1999 Letter. In a subsection of the report, labeled "Without Additional Direction from HCFA, Alternatives to Bundled Rate Methods Have Not Been Developed," the GAO noted that a CMS workgroup established to address the bundled rate issue was not active at the time the GAO issued its report. According to the report, "the group had not made any formal decisions about the future of bundling nor developed alternative payment approaches." The report indicated that all states in its survey with an approved bundled rate continued to use that mechanism for reimbursement and for claiming FFP.

To this date, there has been no further guidance to states regarding bundled rates. At all times since the 1999 Letter, CMS has been fully aware that many states, including the Commonwealth, are claiming FFP based on a bundled rate methodology approved by CMS prior to the 1999 Letter. In fact, as recently as 2000, CMS approved the Division's request to increase the bundled rates. The Commonwealth strongly refutes the OIG's assertion that bundled rates are currently unacceptable for purpose of claiming FFP.

The OIG contends that billing for non-medical services (that is, days on which students do not receive a medical service) under the bundled rate methodology violates federal regulations. The Division disagrees. First, the Division is not aware of a federal regulation that prohibits the CMS-approved bundled rate methodology, and the OIG does not specifically state which federal regulation is being violated. Second, the bundled rate is a composite rate that is based on the average utilization of Medicaid-reimbursable services among Medicaid-eligible special education students. The bundled rates only reflect Medicaid-reimbursable costs; non-medical services were not included in the payment rate. The bundled rate methodology, which spreads costs over all Medicaid-enrolled children with valid IEPs, was designed to account for the fact



that certain Medicaid-eligible special education students either (a) would not have a medical service component listed in their IEPs, or (b) would not actually receive a Medicaid-reimbursable service on a particular day that a bundled rate claim was filed on their behalf. Both factors were specifically addressed in the rate development process, and the approved bundled rates were adjusted accordingly. HCFA participated in the Commonwealth's rate development and approval process. A specific objection was never made to a bundled rate methodology that spreads allowable costs over all Medicaid-eligible students.

## **2. OIG's Findings Regarding the Lack of Service-Specific Documentation**

The OIG found that LEAs did not always maintain the types of medical documentation that (a) established the reasonableness or accuracy of the bundled rate, and (b) served as evidence that services were provided as required under the Medicaid program.

It is important to note that, while the OIG raised concerns about a lack of documentation, the LEAs provided service-specific documentation satisfactory to the OIG in 86% of the cases reviewed. In most of the remaining cases, LEAs presented documentation, such as progress and case notes, that the Division believes provides service-specific support, but that was rejected by the OIG as inadequate.

The OIG's adverse findings regarding documentation are fundamentally based on a rejection of the CMS-approved bundled rate methodology and, as such, are in error. As set forth above, the approved mechanism for reimbursement for school-based services in the Commonwealth is a bundled rate. The rate structure does not contemplate the need to maintain service-specific encounter data to support a claim or the rate of payment. Indeed, on any given day there may be no encounter data for a particular student because no Medicaid-reimbursable service was delivered to that student on that day. Because the rate is fundamentally an average rate, a claim is *not* based on the delivery of a specific service on a specific date to a given student.

## **3. OIG's Findings about Provider Qualifications**

The OIG found that "school-based health services were rendered by health care providers that did not have the qualifications required by DMA Medicaid regulations."

The Division agrees that to the extent LEAs are providing Medicaid-reimbursable services, they must utilize providers who are qualified under applicable state and federal law to provide such services. LEAs are not, however, required to utilize Medicaid-qualified providers to provide educational services. In the audit, the OIG does not describe its process for determining whether a service was educational or medical in nature. The Division is concerned that the OIG lacks the medical, educational, and legal expertise to make such conclusions. Furthermore, as asserted earlier, the Commonwealth's bundled rate methodology accounts for the fact that, on any particular day, a student might receive only IEP services that are educational, non-Medicaid-reimbursable services. Even if a student receives no Medicaid covered services on a day that he/she is in school, (that is, the child does not receive a medical service delivered by a qualified provider that day), the LEA may still claim the appropriate rate for that student.

#### **4. OIG'S Non-Financial Findings – Privacy Concerns**

##### **A. Use of the Internet to Transmit Member Identified Information**

The OIG uncovered one instance where personal information was inappropriately transmitted over the Internet. While any improper transmission of subject identified data is not acceptable, it was inadvertent and is not the ordinary practice of the Commonwealth or its contractor, the University of Massachusetts (UMass), to transmit case-sensitive information over an unencrypted Internet line. All parties have been further reminded about the inappropriate nature of such actions. We are confident this was an isolated incident and will not occur again.

##### **B. Medicaid Enrollee Lists**

Although there was a period when UMass did transmit Division-generated lists of Medicaid-eligible students to LEAs, that practice has been discontinued for over two years. No such list has been prepared by the Division and transmitted by UMass to LEAs since that time. The Division is developing a revised policy to be compliant with the privacy requirements of the Health Insurance Portability and Accountability Act.

#### **5. Financial Finding – OIG Recommendation for Refund of Federal Share of \$2,997,268**

Subject to the resolution of specific LEA disputes, the Division does not dispute the OIG's assertion that where the student was absent, school was not in session, the incorrect student prototype had been used, or the IEP was out-of-date or unavailable, FFP is not available.

The findings relating to documentation and provider qualifications are disputed by the LEAs, and questions between the Division, LEAs, and the OIG regarding the auditors' interpretation and application of regulations in these areas remain unresolved. As outlined throughout this response, the Division argues that the CMS-approved bundled rate methodology negates most of the OIG's findings. However, if any disallowance is deemed appropriate, the Division believes that the OIG's approach to establishing a monetary recommendation is flawed. The OIG does not adequately take into account the fact that the Commonwealth's bundled rates are composites based on utilization of an array of services and are not tied to a particular service. Wherever the OIG determined that a specific service did not meet Medicaid regulations (either because of issues with documentation or provider qualifications), it disallowed the entire amount of the per diem rate claimed. Instead, to properly determine a disallowance, the OIG would need to isolate the value of a specific service and subtract that value from the overall rate. Again, because the rate is an average of all Medicaid covered services spread over all Medicaid-eligible children with IEPs, the actual value of any given service is only a fraction of the composite rate. The Division believes the OIG's approach has resulted in a substantial overstatement of the amount of the inappropriate payment. To the extent that the OIG determines that a disallowance is appropriate, the Division asks that the monetary value of such a determination be reassessed.

#### **Part III. Response to OIG Recommendations**

The following are the OIG's recommendations, as described in the Executive Summary of the audit report. The Division seeks, in this section, to outline its specific response to each recommendation.

Although the Division disputes many of the OIG's findings, the Commonwealth looks forward to working with CMS and the OIG to implement prospective changes, as appropriate, to address the OIG's concerns.

**1. OIG Recommendation: Provide training and technical assistance to LEAs.**

Division Response:

The Division has an ongoing program to train and provide technical assistance to LEAs. In addition to scheduled trainings, individual and group technical assistance and training is available upon request to any LEA. The Division and UMass will continue to provide training and technical assistance for LEAs on a range of issues. In the coming years, trainings will incorporate a specific focus on issues raised by the audit. The Division and UMass will also continue to work with the state Department of Education to ensure that the LEAs are receiving appropriate and comprehensive guidance regarding school-based Medicaid claiming. Trainings and technical assistance will be scheduled, as needed, to address changes in state or federal rules related to school-based Medicaid claiming to ensure that LEAs have the necessary information to remain compliant with all relevant laws, regulations, and program guidelines.

**2. OIG Recommendation: Review all guidance UMass issued to LEAs relative to the Massachusetts Medicaid school-based health program for clarity and completeness and reissue, as needed.**

Division Response:

All existing materials that provide guidance to LEAs on the Municipal Medicaid program are currently being reviewed, and will be revised and reissued as appropriate.

**3. OIG Recommendation: Design a monitoring/audit system to ensure that LEAs comply with Medicaid requirements.**

Division Response:

The Division is evaluating a number of measures aimed at assuring greater fiscal and programmatic integrity of the Municipal Medicaid program. These measures include, but are not limited to, enhanced training, program guidance, and oversight to districts.

**4. OIG Recommendation: Develop a new fee-for-service methodology for school-based health services that complies with federal documentation requirements.**

Division Response:

The Division is actively exploring alternative rate methodologies. Once the state determines the preferred methodology, the Division will work closely with CMS to assure that the payment mechanism is compliant with all federal regulations. The Commonwealth will submit State Plan Amendments or make other changes, as necessary, to implement the most appropriate rate methodology.

Regardless of the payment mechanism, the Division intends to implement mandatory documentation practices for LEAs. The Division, working with the Department of Education and UMass, is already taking steps to implement documentation consistent with materials designed in 2002 in collaboration with the CMS Regions I and II School-based Workgroup. It is

anticipated that participating districts will implement such practices beginning with the fall quarter of the coming school year.

**5. OIG Recommendation: Discontinue providing listings of Medicaid-eligible students to LEAs.**

Division Response:

As set forth above, listings of Medicaid-eligible students are no longer provided to LEAs.

**6. OIG Recommendation: Establish procedures consistent with CMS requirements regarding electronic transmission of data that contain uniquely identifying information.**

Division Response:

Both the Division and UMass are required to comply with privacy requirements established at 45 CFR 160 (HIPAA). HIPAA includes requirements related to electronic transmission of certain personal data. As required by HIPAA, both the Division and UMass employ privacy officers to ensure compliance with applicable privacy laws and regulations. We will continue to ensure that established procedures are consistent with CMS requirements.

**7. OIG Recommendation: Refund to CMS the \$2,997,268 (federal share) that was inappropriately paid by the Medicaid program to the 8 LEAs.**

Division Response:

As described in the body of this response, the Division strenuously disagrees with the OIG's monetary findings.

**Conclusion**

Thank you for the opportunity to respond to this draft audit. The Division looks forward to working with the OIG to provide any additional information necessary as the OIG reconsiders its findings based on this response. In addition, the Division will continue to work with CMS to ensure that prospective changes, as outlined above, are implemented to maintain the integrity of the school-based Medicaid program in the Commonwealth.

Very truly yours,



Douglas S. Brown  
Acting Commissioner